Shared psychotic disorder: a case report in Switzerland

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Abstract

Folie à deux is a rare psychiatric syndrome in which one individual transmits a psychotic symptom to another. In this report, we present a case of folie à deux. The case suggests a possible correlation with neglect, which may have played a role in the development of the symptoms. A 21-year-old Swiss boy and his mother were found to share the same delusional beliefs, forming a case of folie à deux (shared psychotic disorder). The boy had suffered neglect from his parents and was being cared for by his mother, who had no history of mental disorder. The close relationship between the boy and his mother, the family history of first-degree psychosis, and the boy's experience of neglect may have increased his vulnerability to early-onset psychosis and *folie à deux*.

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Introduction

Shared psychotic disorder or induced delusional disorder is a psychiatric entity characterized by similar delusional ideas shared by two or more people who have a close relationship. It was first described by Jules Baillarger in 1860, who called this condition "communicated insanity." Over time, this condition has been differently named: psychosis of association, shared paranoid disorder, and contagious insanity. It was in 1877 that Lasègue and Falret were able to invent the term "*folie à deux*" or "*psicosis de deux*".[1,2] It is a psychiatric entity considered rare; statistics on its incidence and prevalence are not available. The data available in the literature are mainly based on the description of clinical cases. Three surveys examining all clinical case presentations on this pathology have been conducted. From 1877 to 2005, 242 cases were published.[3-5] This entity often involves two people, but rare cases have been described where more than two people are involved, and it is respectively called *folie à deux, folie à trois, folie à quatre*, or *folie à famille*, depending on the number of people involved.[6,7]

Gralnick defined this disorder as a psychiatric condition where delusions are transmitted from one person to one or more individuals closely connected to the primarily affected one.[8] In the 1940s, he categorized this particular disorder into four distinct types: i) *Folie imposee* (imposed psychosis): This variant involves the transfer of delusions from a person experiencing psychosis to another individual who does not exhibit signs of psychosis but shares an intimate relationship with the former. The induced delusions typically fade away once the two are separated; ii) *Folie simultaneous* (simultaneous psychosis): In this category, both partners concurrently share the same psychosis. Prolonged social interactions between them, along with certain risk factors, predispose them to develop this condition. There have been documented cases where genetic factors are shared among siblings, increasing the possibility of simultaneous psychosis; iii) *Folie communiquée* (communicated psychosis): Similar to *folie imposee*, this type is characterized by the transfer of delusions from one person with psychosis to another. However, in this case, the delusional beliefs of the secondary partner emerge after a prolonged period of resistance. Furthermore, the secondary partner may maintain these delusions even after separating from their primary partner; iv) *Folie induite* (induced psychosis): In the fourth type, an individual with psychosis acquires new delusions influenced by another person with psychosis.[8]

Based on the principle of a pre-existing close relationship between the individuals involved, the delirious couple is variable;

they can be spouses, members of the same family, neighbors, or even friends.

The clinical observation we report describes the delusions shared by a boy (inducer) and his mother (imposed psychosis), who lived in a close relationship.

Case Report

This is a clinical observation involving two subjects (A and B). Subject A, 21 years old, is the son of subject B, who is a 41-year-old woman and subject A's mother. The two subjects lived in a house together with subject B's new husband and two boys from her second marriage. Subject B was born and brought up in Serbia, moving to Switzerland at the age of 11 with her family. She attended nursing school and H.R. assistant school, obtaining a community manager degree. She has always worked as a nurse. She got married to a man of Balcan origin, and subject A was born in 2000 from this union. She separated from her husband in 2001 and officially divorced after a few years. She married her current husband in 2006, and two male children, born in 2008 and 2010 from this union, live with the patient and her current husband. Subject A was attending the vocational school for the title of Health and Social Care Assistant.

In their medical-psychiatric background, subject A was known for using ethanol and cannabis, while subject B, after divorcing her husband (and father of subject A) at the age of 20, had needed antidepressant therapy for about 3 months for a depressive state reactive to the event.

The onset of disturbances in subject A dated back about three months before the clinical observation and admission to a psychiatric ward. Subject A developed a persecutory and referential delusion, reporting that he was a victim of a conspiracy controlled by the mafia and religious sects. For this reason, subject A moved to his maternal grandparents' house, since he felt threatened and in danger at his own home. Subject B, coming to share the same delusional ideas as her son, repeatedly alarmed the police and some friends. One day, subjects A and B were then taken by the police to the Emergency Room where a psychiatric consultation was performed, which, considering the presence of delusions and the total lack of insight in the two patients, recommended hospitalization on a medical order for both subjects.

Subject B reported not sleeping, not leaving home and not going to work for about 10 days.

At the psychiatric evaluation, it was noted: i) Subject A, who at the first observation was dressed in a white tunic due to religious delusions and presented with delusional ideation with a theme of persecution and reference, said: "Believers in God are looking for me, they want to kill me..."; he also said: "The mafia is on my trail, I can't let them find me, they want money from me but they won't find me"; ii) Subject A showed a state of psychomotor agitation associated with logorrhea and insomnia. The mood was expanded, even with delusional ideas of grandeur: "You can't keep me here, you don't know who I am, I'm the head of a religious sect, you don't know who you're dealing with...". Insight was absent and adherence to the prescribed pharmacological therapy was poor; iii) Subject B, also dressed in a white tunic like subject A, presented with asthenia, insomnia ("I haven't slept for about 10 days, I can't remember the last time I left home"), expressing the same delusional ideas of persecution as subject A with a mechanism that had evolved for two months ("I'm afraid for my son's life, they're looking for him, they want to kill him, a sect of religious fanatics, the mafia, everyone"); iv) Unlike subject A, subject B showed greater therapeutic adherence, accepting the hospitalization regime, reporting benefit from the protective atmosphere of the hospital.

Subject A was hospitalized and treated with Haloperidol (10 mg once a day), Sodium Valproate (600 mg once a day), Olanzapine (10 mg twice a day) and Diazepam (10 mg a day). He had also received supportive psychotherapy and after two weeks his clinical condition had improved, although there were still delusional episodes. In addition, subject A presented with traits of immaturity, dependence and poor mentalization capacity. After hospitalization, subject A returned home but in a social context far from subject B, with psychiatric follow-up care activated at the territorial level.

Subject B was hospitalized in another unit of the Psychiatric Clinic and treated with Risperidone (3 mg once a day for two weeks) but as early as the second day of hospitalization, she acquired critical awareness about her thoughts and her son's ones. The psychopathological picture presented by subject B had undergone complete resolution of psychotic symptoms compared to subject A. At the time of discharge, at home with her husband, the woman showed adequate insight into her illness and appeared critical of all the events that had occurred in the last months. The woman was also connected with a psychiatrist at the territorial level.

Discussion

In the case presented, subjects A and B were both in their first psychiatric admission. The family context was certainly characterized by frequent arguments subject A's parents had been divorced for years and did not have a good relationship. When the two subjects (A and B) arrived at our Psychiatric Clinic, it was decided to admit them to separate departments and to avoid contact between the two. They both were prescribed pharmacological therapy and gradually a clinical improvement was observed. The clinical improvement occurred much more quickly in subject B compared to subject A.

Shared Psychotic Disorder is characterized by similar delusions shared by people who have a close relationship and who typically live together in relative social isolation.[7,9] In our clinical case, the two subjects had remained together and had had minimal contact with relatives or friends. Subject A (the son) was dominant and the one who had initiated the delusions he had gradually imposed on subject B, who was passive and dependent by nature. The inducing and induced subjects lived in increasing isolation and tended to be ever more suspicious. They felt threatened by an increasingly hostile atmosphere, which in turn led to a paranoid reaction, and even to a real paranoid psychosis.

Subject B was concerned about her son's health condition but she did not want him to be followed on an outpatient or inpatient psychiatric basis for fear of the stigma; she also wanted to prevent him from living with his father and his relatives. Isolation and the relational closure between the two caused the mother's development of an induced psychosis. Subjects A and B did not allow other family members to intervene even though the family members themselves realized that something was wrong.

At the end of both subjects' hospitalization, a diagnosis of Psychotic Disorder was made according to the DSM-5.[10] The criteria for a diagnosis of "Other Specified Schizophrenia Spectrum and Other Psychotic Disorder" (ICD-10 code F28.0) were met in

subject B, while subject A met the criteria for Delusional Disorder (ICD-10 code F22).[10] The key aspect in the etiology and psychopathology of shared madness is the nature of the relationship between the inducer and the induced.[9] In our observation, subject B was intimately linked to subject A (her son), both physically and emotionally. Several authors have emphasized the function of the delusion for one or the other of the subjects: the delusion appears to be advantageous for both protagonists in some ways,[11] it allows the preservation of isolation and group cohesion and the secondary subject may accept the delusion to maintain the relationship with his/her delusional partner.[8,12] Sometimes the outbreak of the delusion in the primary subject is favored by the secondary subject, explaining the ease of the latter in adhering to the delusion.[13] The main recommended therapeutic measure is to separate the affected subjects. As confirmed in other cases in the literature, the induced subject improved faster than the inducing subject.[1,10] In the described case, subject A was hospitalized and separated from subject B in another department of the Clinic. However, it is to be noted that it is not always obvious that separation alone can allow the recovery of the induced and inducing subjects. This is why, as suggested by other authors,[6,8,9,14] we also added a psychopharmacological treatment to both subjects.

Conclusions

In this reported case, the inducer who shared his delusions with his mother had a dominant position over the induced subject, who appeared fragile and with traits of dependence. The resolution of the clinical picture in the secondary subject (B) was much faster mainly because of their separation rather than drug therapy.

This is a rare case and the first we have been able to observe in our Clinic despite the high number of beds (146) and the subsequent hospitalizations carried out.

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